

**FORM C**  
**VOLUNTEERS IN MEDICINE - VERIFICATION OF EMPLOYMENT**

**INSTRUCTION: This form must be completed by the applicant's employer documenting the applicant's agreement not to receive compensation for any medical services rendered while practicing with a VIM license. This form must be completed by the agency, institution or facility where you will be doing the volunteer work and must complete and notarize this form. This form must be sent directly to the Board from the verifying authority.**

I hereby attest that \_\_\_\_\_ who will be working in the employment of  
PHYSICIAN'S NAME

\_\_\_\_\_ shall unequivocally not receive compensation for  
FACILITY/AGENCY NAME

Any medical services he or she may render while in possession of a Volunteer in Medicine License.

I further attest that this is a public agency or institution, not for profit agency, not for profit institution; or not for profit corporation and further, we provide services only to indigent patients in medically underserved areas or critical need population areas of the State.

\_\_\_\_\_  
Printed name of OWNER/CEO

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
Printed name of Physician

\_\_\_\_\_  
FACILITY/INSTITUTION/AGENCY

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY/STATE/ZIP

\_\_\_\_\_  
(AREA CODE) TELEPHONE NUMBER

\_\_\_\_\_  
SIGNATURE OF OWNER/CEO

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CITY

\_\_\_\_\_  
COUNTY

\_\_\_\_\_  
STATE

Sworn and subscribed to me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

My Commission Expires

\_\_\_\_\_  
(Notary Public)

NOTARY  
SEAL  
MUST  
BE IMPRINTED  
HERE